Section B

ACTIVE SUBSCRIBERS

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Eligibility and Enrollment Rules and Procedures

Notes on Eligibility

- An employee who moves from one participating employer to another, with no break in coverage or with no more than a 15-calendar-day break in employment, is considered a transfer, not a new hire. Refer to the Transfers and Terminations section of this manual for transfer rules and procedures.
- An academic employee (public school districts, universities, colleges, and technical colleges) who completes a school term and moves to another academic setting with another participating academic employer at the beginning of the next school term is a transfer, not a new hire. Refer to the Transfers and Terminations section for transfer rules and procedures.
- Employees who participate under the TERI program remain under the active group insurance program and are entitled to the same benefits and enrollment rules as non-TERI employees.

Both Spouses Employed by State-Covered Employers

- A husband and wife employed by participating employers and eligible for coverage as permanent full-time employees must enroll as employee subscribers.
- Neither can be covered as a dependent.
- An employee cannot be a subscriber and a dependent at the same time.
- Spouses are not required to carry the same health coverage; however, the family deductibles will not apply unless they elect the same health plan.
- If a covered spouse becomes eligible as an employee of a participating employer, the employee subscriber must drop the spousal coverage, effective with the date of coverage for the spouse as an employee. This applies to MoneyPlu\$ participants also, since this qualifies as a change in family status. The change to delete a spouse (new employee) from existing coverage must be completed within 31 days of the spouse's date of hire.
- Two covered employees cannot cover the same child under the same program (health, dental, dependent life).

Refusal of Coverage Rules

An employee may refuse enrollment in any or all of the benefits plans offered by the state. If an employee refuses health coverage, he forfeits Basic Life and Basic LTD coverage.

To refuse coverage, the employee must complete the following sections of the NOE:

- Section A Action: check new hire;
- Section B Enrollee: complete Blocks 1 18;
- Section C Coverage: Check refuse for each program refused; and
- Sign and date the certification statement at the bottom of the NOE.
- The BA should:
 - Complete the BA USE ONLY section;
 - Sign and date the NOE;
 - Distribute copies as indicated on the bottom of the NOE; and
 - Mail the NOE to EIP.
- Make sure employees sign an NOE and any other benefit enrollment forms. Send the original NOE refusal to EIP.
- DO NOT send refusals for SLTD; keep a copy of the SLTD enrollment form, indicating the refusal, in the employee's file.

Assisting an Eligible New Employee

Prepare an information packet as outlined below. If the new employee is a transfer, refer to the Transfers and Terminations section. Use the New Hire Orientation Checklist on Page B-8 to ensure that you have covered all benefit information.

Information Packet

The new employee's information packet should include the following items:
☐ Active NOE form
☐ Insurance Benefits Guide
☐ The Insurance Advantage (during October only)
☐ HMO information, if available in service area in which the employee works or lives
☐ TRICARE Supplement information, if applicable
☐ Prevention Partners brochure
☐ Preventive Worksite Screening brochure
☐ MoneyPlu\$ brochure
☐ MoneyPlu\$ Flexible Spending Account Enrollment form
☐ LTC Personal Worksheet and Enrollment form
☐LTC Medical Questionnaire for spouses, parents and parent-in-laws, if requested by subscriber
□ SLTD Enrollment form/brochure
☐ HIPAA Privacy Notice
Daview Penefite Aveilable
Review Benefits Available
Explain the following benefits to the new employee. The new employee must choose or refuse one or all of the
following, based on eligibility:
Health:
☐ State Health Plan (include prescription drugs and mental health/substance abuse)
☐ Preventive worksite screening benefit
☐ Well Child Care benefit
□ Pap Test benefit
☐ Mammography Testing benefit
☐ Maternity Management benefit
☐ HMO options (with or without point-of-service option)
☐ TRICARE Supplement, if eligible
Dental:
State Dental Plan
□ Dental Plus
Life Insurance:
Basic Life
Optional Life
Dependent Life/Child(ren)
Dependent Life/Spouse
MoneyPlu\$:
Pretax Premium feature
☐ Medical Spending Account

□ Dependent Care Account □ Long Term Care (LTC) Long Term Disability: □ Basic Long Term Disability (BLTD) □ Supplemental Long Term Disability (SLTD) □ Vision Care
 □ Explain how to enroll for benefits. □ Enrollment forms must be completed and signed within 31 days of date of hire or a special eligibility situation (birth, marriage, adoption or placement, involuntary loss of coverage). □ If not completed within 31 days, he must provide medical evidence of good health for Optional Life (if not on MoneyPlu\$ pre-tax premium feature), Spouse Dependent Life, LTC and SLTD coverage, and wait for the next open enrollment period or a special eligibility situation to select health and/or dental. □ If possible, have the employee complete the NOE and any other form(s) required immediately before, during or after orientation.
☐ Explain late entrant procedures (providing medical evidence of good health), open enrollment, special eligibility situations, the effective date (if medical evidence is approved), and pre-existing limitations that apply to late entrants of Optional Life, Dependent Life, LTC and SLTD.
□ Advise the employee that coverage begins: □ On the first day of the month he begins active employment, if the employee begins active employment on the first working day of the month. Otherwise, coverage begins on the first day of the following month. □ If the employee is not actively at work on the date he otherwise would become eligible, coverage will begin on the first day of the month coinciding with or following the day he returns to work. □ Dependent coverage will become effective the same day as the employee's.
□ Explain the pre-existing provision, all limitations and any penalties that apply to the State Health Plan and Medi-Call, the HMO/POS, BLTD, SLTD and LTC. Also explain that a certificate of prior coverage may be used to offset/reduce the health plan pre-existing condition limitation period.
□ Explain the SHP requirements for Medi-Call, Mental Health and Substance Abuse benefits, Maternity Management benefits, Pap Test benefit, Worksite Screening benefit, the hospital and physician networks, the Prescription Drug Program and the Well Child Care benefit.
☐ For HMO coverage, explain the primary care physician (PCP) requirement and referrals for specialty care. For POS coverage, explain out-of-network options.
☐ Explain how to file claims for benefits and that completed claim forms should be submitted as services are rendered. Forms are also available on the EIP Web site.
☐ Upon enrollment, send the COBRA initial notification to the employee and also to the spouse if the spouse and or dependent children are covered.

New Hire Orientation Checklist

At your option, you may wish to have new employees sign a statement, confirming you reviewed all eligible benefits with them as outlined in this checklist. EIP does not require this; it is only for your information and records.

Eligibility Rules Checklist
□ Employee
□ Spouse
☐ Dependent children
Health Orientation
□ Plans available
□ Effective date
□ SHP benefits including Prescription Drug Program, mental health/substance abuse coverage; provider networks, Preventive Worksite Screening benefit □ HMO/POS/TRICARE Supplement benefits, if applicable
□ Pre-existing condition limitation
☐ Certification of prior coverage
Review rates
☐ If employee refuses health coverage, he forfeits Basic LTD and Basic Life
☐ Enrollment period: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days of date of hire
State Dental Plan
Benefits
☐ Fee schedule and allowable charges
☐ Review rates
☐ Enrollment period: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days
Dental Plus
□Benefits
☐ Fee schedule and allowable charges
☐ Review rates
☐ Enrollment period: must wait until next open enrollment period or special eligibility situation if not enrolled within 31 days
Dependent Life/Child(ren)
Coverage level
☐ Dependents not enrolled (not listed on NOE) will not be covered ☐ Rate
☐ Eligible children may be added throughout the year without providing medical evidence of good health ☐ Explain the deferred effective date provision, if applicable. Additional information is in the Spouses and Dependents section of the manual.
Dependent Life/Spouse
Coverage level options
Review rates
☐ Medical evidence is required if the spouse is not added within 31 days of first eligibility

☐ Explain the deferred effective date provision, if applicable. Additional information is in the Spouses and Dependents section of the manual.
Optional Life □ Review coverage levels □ Subscribers participating in the MoneyPlu\$ pretax premium feature: □ May select, increase, decrease or cancel coverage within 31 days of a special eligibility situation (depending on the event) □ Submit medical evidence of good health during an enrollment period if: □ Not enrolled within 31 days of hire date □ Not selected or increased within 31 days of a special eligibility situation □ Cannot decrease or cancel the coverage except during an enrollment period if request is not made within 31 days of a special eligibility situation □ Subscribers not participating in the MoneyPlu\$ pretax premium features: □ May submit medical evidence of good health year round to select or increase coverage □ May decrease or cancel coverage effective the first of the month after request is made □ Review rates □ Rate increase by age category
Long Term Care ☐ Review plans and benefits ☐ Pre-existing condition limitation ☐ Medical evidence required for spouse, parents, and parents-in-law (year-round enrollment) ☐ Review rates, spousal discount if both spouses enroll in the service reimbursement plans ☐ Employee medical evidence required if not enrolled within 31 days of hire date (year-round enrollment)
MoneyPlu\$ □ Review Pretax Group Insurance Premium Feature □ Review Medical Spending Account (one year of continuous employment at a participating employer is required) □ Review Dependent Care Account □ IRS restrictions - changes only during enrollment period or within 31 days of family status change □ Reimbursed through claim to FBMC (direct deposit option; \$5 reimbursement minimum): □ Medical Spending Account-with receipts for all services and supplies and Explanation of Benefits forms reflecting deductible and coinsurance amounts. Full election amount available □ Dependent Care Account-with receipt and tax ID of care provider. Sufficient funds must be in account □ Administrative fee
Supplemental Long Term Disability ☐ Review benefits ☐ Pre-existing condition limitation ☐ Medical evidence is required if not enrolled within 31 days of eligibility (year-round enrollment) ☐ Review rates
Vision Care Program ☐ Discount program ☐ Refer to Vision Care Program Provider Directory online ☐ Not related to health plans (not a reimbursable expense)

Assisting the New Hire With Enrollment

The new employee is allowed to change his mind about an original selection within 31 days of his date of hire. To make a new selection within the 31 days of his date of hire (not coverage effective date), a new NOE must be signed within the 31-day (calendar days) window and submitted to EIP for processing.

Completing the NOE

NOE forms are available on the EIP Web site. NOE forms may be completed online and then printed and signed.

- Complete the NOE in BLACK INK.
- Altered NOEs are not acceptable.
- Photocopies of NOEs are not acceptable.
- Do not use highlighters on NOEs.
- The employee is wholly responsible for the information on the form(s) he signs.

The employee completes:

Section "A" Action

- 1. Check "New Hire."
 - BA should complete BA USE ONLY section.
 - BA must indicate the employee's status with flexible benefits (do not omit). This is for premium conversion only.

Section "B" Enrollee

- 1. The SSN (verify with SSN card)
- 2.-5. Full name (suggest using given legal name): *as it will appear on a claim*, including suffix (Jr., Sr., II, III, etc.)
- 6. Medicare number, if applicable. Parts A & B: the date Medicare coverage was effective (dates on Medicare card)
- 7. Birth date
- 8. Sex
- 9. Marital status: must check one
- 10. Phone number (optional)
- 11.-13. Mailing address: current and complete
- 14. State: a must do not assume SC
- 15. ZIP code: a must (9 digits if known)
- 16. County code: the county where the mailing address is located (see county code listing in Reference Section).
- 17. Annual salary: per year, not hourly wages or monthly salary
- 18. Date of hire: date employee reports to work, not contract or signature date

Section "C" Coverage

19. **HEALTH**: Must elect a health plan and category of coverage or check "refuse." If an HMO or POS is selected, the HMO or POS must be listed.

The carrier generates health ID cards and sends them directly to subscribers.

Dependents must be listed on the NOE to be covered.

Pre-existing condition (refer to the Glossary in the Reference section of manual) limitations apply to any enrollee or dependent who has a break in coverage or who never has been covered under any state-offered group health plan. Certification of prior coverage may be provided to offset/reduce the pre-existing condition limitation, provided there is no more than a 62-day break in coverage.

- 20. **DENTAL**: Must elect a category of dental coverage or check "refuse." Must indicate "yes" or "no" under Dental Plus.
 - Must elect the State Dental Plan to participate in the Dental Plus benefit.
 - The level of coverage selected for the State Dental Plan and Dental Plus will be the same.
 - Dependents must be listed on the NOE to be covered.
 - Issue a State Dental Plan ID card to the employee. Write the employee's SSN on the card. The employee uses his SSN to file covered dependents' claims.
 - Dental Plus subscribers will receive a dental insurance card in the mail.
- 21. **DEPENDENT LIFE/CHILD(REN):** Must refuse or enroll (child coverage level is \$10,000).
 - An employee can purchase Dependent Life/Child(ren) for any of his eligible dependent children.
 - The employee is the beneficiary for all covered dependents.
 - Dependents must be listed on the NOE to be covered.
 - Dependents may be added or cancelled throughout the year, effective the first of the month after request. No medical evidence of good health is required.
 - If both husband and wife are state employees, only one can carry dependent coverage for eligible dependent children.
 - Dependents are not eligible for claims payment under the age of 14 days.
 - There are no accidental death or dismemberment benefits for Dependent Life/Child(ren).
 - The deferred effective date may apply if the child is confined to a hospital or elsewhere because of a physical or mental condition.
- 22. **DEPENDENT LIFE/SPOUSE**: Must refuse or enter a coverage level (\$10,000 \$100,000, not to exceed 50% of subscriber's level of coverage).
 - An employee can purchase Dependent Life/Spouse coverage for his spouse (if the spouse is not eligible for benefits as a full-time employee).
 - The employee must enroll the spouse in Dependent Life/Spouse coverage within 31 days of first eligibility or medical evidence of good health will be required.
 - Any spouse in full-time military service is NOT eligible for Dependent Life/Spouse coverage.
 - Medical evidence of good health is required if:
 - Requested coverage is greater than \$20,000;
 - The spouse is not added within 31 days of first eligibility:
 - ° Date of hire, if spouse is not an eligible employee;
 - ° Date of marriage;
 - Date spouse is no longer eligible as an active employee. (Note: A spouse who is a retiree subscriber may be covered on Dependent Life/Spouse as a dependent. However, a spouse cannot be covered as a dependent on Dependent Life/Spouse if the spouse is in a 12-month waiver of premium status as a subscriber on Optional Life. He may be added as a dependent if done within 31 days of the ending of his Optional Life waiver.)
 - The spouse must be listed on the NOE to be covered.
 - Dependent Life/Spouse has the same Accidental Death and Dismemberment (AD&D) benefits as the subscriber's Optional Life Accidental Death and Dismemberment benefits including the Seat Belt Benefit, the Daycare Benefit, The Education Benefit and the Felonious Assault Benefit.
 - The deferred effective date may apply if the spouse is confined to a hospital or elsewhere because of a physical or mental condition.

- 23. **OPTIONAL LIFE:** Must elect a level of Optional Life coverage or check "refuse" (\$10,000 \$500,000, not to exceed three times salary, rounded down)
 - The new hire may request a level greater than three times the annual salary, up to the maximum, by submitting medical evidence of good health.
 - Employees participating in the pretax premium feature (MoneyPlu\$) must make the medical underwriting request within 31 days of the date of hire. The NOE must be signed within 31 days of the date of hire. The medical questionnaire must be signed and forwarded to The Hartford within 31 days of the date of hire of an employee participating in the MoneyPlu\$ pretax premium feature. The effective date for the higher level will be the first of the month after approval.
 - (NOTE: Employee should submit the original new hire NOE with the maximum allowed by salary. A second NOE for the total amount desired should be completed and held for the approval from The Hartford.)
 - Employees NOT participating in the pre-tax premium feature (MoneyPlu\$) may apply for additional coverage, up to the maximum, throughout the year by submitting medical evidence of good health. The effective date for the higher level will be the first of the month after approval.
 - For employees age 70 and older, mark the NOE for the coverage amount as if the employee were under age 70. The system will convert the amount and the premium to the age 70 level.
- 24. **Basic Life and Basic LTD**: No election is required for Basic Life or Basic LTD coverage. However, the employee must be enrolled in a health plan to receive benefits.

Section "D" Dependents

Refer to the Spouses and Dependents section for additional information regarding eligibility and required documentation.

- 25-1. List the information on the spouse first. (Because of coordination of benefits, this information is required even if the spouse is not covered.)
 - Include the SSN: required.
 - Medicare number and Medicare effective date, if entitled, due to:
 - Age 65 and over:
 - Disability after 29 months
 - End stages of renal failure
 - Last name, first name and sex of spouse. List the name as it will appear on a claim (suggest using the given legal name).
 - Relationship: list as wife, husband, ex-wife, ex-husband. **Do not use "spouse."**
 - Spouse's birth date.
- 25-2. List all dependent children to be covered. If not listed, they will not be covered.
 - Follow the same procedure for children as for the spouse, beginning with the SSN.
 - Relationship: list as son, daughter, niece, nephew, etc., not child.
 - List the name as it will appear on a claim (suggest using the given legal name).

Section "E" Beneficiaries

- 26. Do not make any alterations in this section. If a mistake is made, complete a new NOE.
 - List a beneficiary for Basic Life, if health coverage is elected.
 - List a beneficiary for Optional Life, if this coverage is elected.
 - List each beneficiary's SSN, full name (for example: Jane Doe, not Mrs. John Doe or Mrs. Doe or Mrs. J. Doe), relationship to the subscriber and the beneficiary's birth date.
 - If the number of beneficiaries exceeds the allotted space on the NOE, the employee should indicate on the bottom of the NOE that beneficiaries are continued on an attachment. On the attachment,

indicate employee's name, SSN and the life program with necessary beneficiary information. The attachment must be signed and dated by the employee and stapled to the NOE.

- List relationship as wife, husband, daughter, son, etc. An estate or trust has no relationship.
- Indicate percentages (not dollar amounts) when multiple beneficiaries are listed; otherwise, the benefits will be divided equally among the beneficiaries.
- For a trust, the employee must list the name and address of the trust institution and the date the trust was signed.
- For a living trust that has been executed through an attorney, the employee must supply as much
 information as possible on the NOE. In the case of death, usually the trust document names a successor.

Section "F" Certification and Authorization

- 27. Signed and dated by the employee.
- 28. Signed and dated by the BA.

The employee is solely responsible for what he signs. Each employee should read the conditions and authorizations at the bottom of the NOE. The back of the NOE contains step-by-step instructions on completing the NOE. If an employee is unable to sign the NOE, a witness should verify the employee's signature "X."

Creditable Coverage Documentation

Creditable coverage is prior coverage under a health plan, or insurance coverage or health benefits provided by certain state and federal statutes, as described or defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Creditable coverage may be used to reduce a pre-existing condition limitation provided the prior coverage is continuous. Prior coverage is considered continuous if the break in coverage does not exceed 62 days.

A copy of the creditable coverage letter from the prior carrier should be stapled to the NOE. The letter should state the type of coverage, the beginning date of the coverage, the ending date of the coverage (or indicate if it is still effective), and must list the dependents covered. This information will be processed with the NOE. The new health carrier will notify the subscriber of any pre-existing time left if the creditable coverage submitted is less than 12 months. No notification will be sent if the 12-month, pre-existing period has been satisfied.

NOTE: The creditable coverage document may be sent later; however, the subscriber should be advised that he/she will receive notification from the carrier of the pre-existing status at the time the new hire NOE is processed. If the creditable coverage letter showing 12 months of prior service is sent separately from the NOE, the subscriber will not receive notification from the carrier. However, he/she will receive notification of any time remaining if the full 12 months have not been satisfied. EIP will notify the subscriber of the pre-existing status of any creditable coverage processed separately from the new hire application.

THE SUBSCRIBER'S NAME AND SSN MUST BE AT THE TOP OF THE CREDITABLE COVERAGE DOCUMENT WHETHER STAPLED TO THE NEW HIRE NOE OR SUBMITTED SEPARATELY.

Check the NOE for the following:

NOE Final Checklist - New Hire

☐ The NOE is an original - photocopies are unacceptable.
☐ The NOE is completed using BLACK INK .
□ No alterations appear (for example: strikeovers, correction fluid, multiple checks) in the coverage areas (blocks #19, 20, 21, 22, 23).
☐ No alterations appear in block #26.
☐ No Ditto marks or "same as above" written in.
☐ The NOE is dated and signed by the employee (block #27).
☐ The NOE is dated and signed by the BA (block #28).
☐ The employee selected coverage or checked "refuse" for all programs. If an HMO or POS is selected, the employee must list the name of the HMO or POS.
☐ Any required documents are attached (stapled to the NOE):
☐ Dependents With Same or Different Last Name Form
☐ Student Certification Form
☐ Incapacitated Child Certification Form
☐ Custody/guardianship appointment (legal document or supporting document and Establishment of Custody Form)
☐ Divorce decree (court order to cover ex-spouse or children)
☐ Temporary adoption/custody/final adoption (legal document)
☐ Certificate(s) of prior coverage (from prior group carrier)
☐ Documentation of common law marriage
☐ Each attachment has the employee's name, SSN and the plan designation.
☐ SSNs and dates of birth for dependents are complete and, if applicable, state-employee spouse is indicated.
☐ Complete the BA USE ONLY area, sign and date the NOE and any appropriate documentation and staple any attachments to the NOE.
☐ Keep a copy of the NOE and any documentation for your file and forward appropriate payroll deduction
form(s).

Supplemental Long Term Disability Enrollment

Coverage Effective Dates

For new employees enrolling within 31 days of their hire date, coverage is effective as follows:

- If their date of hire is the first of the month, the effective date will be the first of that month.
- If the date of hire is the first working day of the month, coverage may be effective on the first of that month.
- Otherwise, the effective date will be the first of the month following the date of hire.

NOTE: If physical disease, mental disorder, injury or pregnancy prevents the employee from working the day before the scheduled effective date of SLTD insurance, the insurance will not become effective until the day after the subscriber completes one full day of active work.

Premium Changes

- If SLTD premiums for the state group are adjusted on a class basis for all plan participants, these adjusted rates will be passed on to all plan participants.
- Premiums are based on an employee's age as of the previous December 31 and salary as of the previous October 1.

Completing the SLTD Enrollment Form

- Check New Add.
- Select Plan One (90-day benefit waiting period), Plan Two (180-day benefit waiting period), or Refuse.*
- If the subscriber chooses the 90-day Benefit and later decides the 180-day Plan is better for him, he may submit another application indicating "Increase benefit waiting period" to Plan Two (180-day benefit waiting period); however, should he choose Plan Two and later decide to change to Plan 1, medical underwriting will be required.
- BA USE ONLY-Enter the effective date of coverage. Indicate the Group ID number. Indicate the Group name.
- The subscriber needs to complete the next section in its entirety. Make sure the salary indicated is the AN-NUAL contract salary (not to include bonuses, overtime, incentive, or compensation pay).
- The subscriber must sign the form and date the form (use the date the subscriber actually signs the form).
- The BA must sign and date the form.
- Make a copy for the subscriber's file. Attach the original to the NOE and forward to EIP for processing. This
 application may be sent separately from the NOE; however, submitting it along with the new hire NOE assures
 faster processing.

*Note: If the subscriber refuses coverage, DO NOT send the application to EIP; keep it in the employee's file.

Long Term Care Enrollment

Coverage Effective Dates

For new employees enrolling within 31 days of their hire date, coverage is effective as follows:

- If their date of hire is the first, the effective date will be the first of that month.
- If the date of hire is the first working day of the month, coverage may be effective on the first of that month.
- Otherwise, the effective date will be the first of the month following the date of hire.

Entry Age Determination

- For new employees enrolling within 31 days of their hire date, entry age is their age as of the date of their application (date the employee signs the Long Term Care form).
- For a guaranteed issue increase, the age is the applicant's age as of the signature date on the guarantee issue form.
- For coverage requiring medical underwriting (late entrant), the age is the applicant's age as of the date Aetna receives the application and medical questionnaire.

Premium Changes

- If LTC insurance premiums for South Carolina are adjusted on a class basis for all plan participants, these adjusted rates will be passed on to all plan participants.
- Premiums also will change for those who increase their benefit option. The cost of the additional coverage will
 be based on the age at the time of purchase. The new premium includes the original premium plus the cost of
 any additional units of coverage purchased at the later age.

Premium Waiver

While receiving benefits, premiums are waived as follows:

- Premiums will be waived upon satisfying the waiting period.
- Premium payments will resume on the first premium due date following the date the individual is no longer receiving benefits.
- Premium payments will continue for any other covered family members, such as a spouse, parents or parents-in-law, not receiving benefits.

Completing the Long Term Care Insurance Employee Enrollment Form

Call Aetna at the toll-free number on the form for assistance in completing it.

Part A: Employee Information

• Complete the information about the employee. Name, SSN, address, date of birth, sex and beneficiary information must be completed. Be sure to indicate if the spouse is enrolling.

Part B: Plan Options/Daily Benefit Amount

- Select the type of plan (disability or one of the service reimbursement plans).
- Select the amount of daily benefit-Mark only one amount and DO NOT ALTER.

Part C: Certification/Authorization

• Enrollee must sign and date the form.

Part D: Protection Against Unintended Lapse

• The enrollee must either designate another person to receive notice if the enrollee's LTC coverage is about to lapse, or the enrollee must sign and date the waiver.

Part E: LTC Insurance Replacement Questions

• The enrollee must answer the questions and sign and date the form in order for it to be processed by Aetna.

Make a copy for your files and a copy for the subscriber.

Attach the original to the NOE and forward to EIP for processing. The application may be sent separately; however, submitting it along with the NOE assures faster processing.

MoneyPlu\$ Enrollment

MoneyPlu\$ is offered to all active employees who are also eligible for health and dental insurance coverage, whether or not they are enrolled in coverage. This program, administered by Fringe Benefits Management Company (FBMC), was designed in compliance with sections 105, 125 and 129 of the Internal Revenue Code (IRC).

MoneyPlu\$ has three features: the Pretax Group Insurance Premium Feature, the Dependent Care Spending Account and the Medical Spending Account. Refer to the IBG for information regarding these features.

Effect of MoneyPlu\$ On Other Retirement Plans

State Retirement Plan

Participation in MoneyPlu\$ has no effect on SCRS retirement pension contributions or benefits.

Deferred Compensation

Pretax dollars set aside for MoneyPlu\$ elections are not included in income when determining the maximum that can be contributed to a Deferred Compensation account.

Tax Deferred Annuity Plans for School Employees

Pretax dollars set aside for MoneyPlu\$ elections are not included in income when determining the maximum that can be contributed to a tax-deferred annuity.

Social Security

Pretax dollars set aside for MoneyPlu\$ elections are not subject to Social Security taxes. Therefore, there may be a slight reduction in future Social Security benefits.

Employees do not typically contribute to a Dependent Care Spending Account for more than a few years, but employees may contribute to a Medical Spending Account for many years, and the amounts contributed may vary significantly, year to year.

The effect on future Social Security benefits is usually small, and in most cases the value of the tax savings exceeds the value of the benefits lost by a considerable margin.

The Tax Savings Analysis software on FBMC's Web site may help estimate the effect of MoneyPlu\$ participation on future Social Security benefits. Employees should consult their tax preparer/advisor to discuss their options.

If Both Spouses Are Eligible

- If both spouses are eligible employees, each may participate in the MoneyPlu\$ program.
- Either spouse may claim an expense, but not both.

Effective Dates for Enrollment and Changes

The effective dates for enrollment and changes are the same as for health and dental insurance. Eligible employees have 31 days to enroll or to make changes due to a qualifying change in status. Refer to the MoneyPlu\$ Change in Status form for eligible changes and their effective dates.

Assisting an Employee With MoneyPlu\$ Enrollment Pretax Premium Feature

- To participate, check YES in the MoneyPlu\$ box on the NOE; to decline, check NO.
 - A MoneyPlu\$ Refusal to Participate form is no longer required. The form is still available on the EIP Web site, however, if you prefer to use it and keep it on file as a record of the participant's refusal.
 - If left unchecked, the default selection is YES.
- Be sure to forward the election to your payroll office.

An employee does not have to participate in the Pretax Premium feature to participate in the spending accounts.

Medical Spending Account and Dependent Care Account

- Provide a copy of the Flexible Benefits Plan booklet from FBMC.
- Provide a copy of the Flexible Spending Accounts Worksheet.
- Refer the employee to the Tax Savings Analysis software on FBMC's Web site.
- To participate in either account, the employee completes a Flexible Spending Account Enrollment Form.
- The deduction amount entered on the form should be PER PAYCHECK, not per month.
- If the employee is retiring, the amount elected should be estimated based on the number of paychecks prior to retirement
- The BA must complete and sign the bottom portion.
- Give a copy to your employee and forward a copy to FBMC.
- If FBMC makes a change to the enrollment form, a copy will be sent to you for correction in your system.
- If the employee participates in one of the spending accounts, be sure to provide a Direct Deposit Authorization Form.

Comptroller-General Agencies Only

• If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Dependent Care Spending Account and Medical Spending Account Rules

- Expenses are reimbursable only if incurred during the employee's period of coverage within the plan year.
- Participants may not be reimbursed twice for the same expense; an expense is not reimbursable if it is already covered under insurance or has been claimed through a spouse's flexible spending account.
- By IRS regulations, amounts not claimed after the year's end cannot be returned to the employee or carried forward to a new plan year.
 - An employee has a 90-day grace period (until March 31) to file claims for services incurred during the previous year.
 - ° FBMC provides quarterly statements to employees who have not used their account in any given quarter.
 - ° FBMC sends the third-quarter statement to all employees, regardless of account activity, reminding them of the 90-day grace period.

Dependent Care Accounts Only

- Sufficient funds must be available for eligible expenses to be reimbursed.
- Funds are posted to participants' accounts upon processing of MoneyPlu\$ payrolls.
- Claims for which there are insufficient funds will be held and processed as the funds become available; the employee should not need to refile.
- The expense (or period of service, such as a month's worth of daycare) must be incurred prior to reimbursement.

Medical Spending Accounts Only

- Generally, the expense must be incurred prior to reimbursement.
- Orthodontia-There are special rules regarding orthodontia:
 - A contract or letter of medical necessity is required to verify the procedure is not for cosmetic reasons.
 - The initial service (banding) must have occurred before reimbursements may begin.
 - The contract payment schedule will need to be reviewed before reimbursements may begin.

Refer the employee to the MoneyPlu\$ Flexible Benefits Plan booklet for details.

Assisting a Permanent, Part-Time Teacher

Permanent, part-time teachers (as defined by the employer) of South Carolina public schools, the South Carolina Department of Corrections and the South Carolina Department of Juvenile Justice may be eligible for:

- State health and dental benefits
- MoneyPlu\$ benefits
- Vision care benefits

Permanent, part-time teachers are not eligible for:

- · Basic Life Insurance
- Basic LTD or Supplemental LTD
- Dependent Life Insurance for children or spouses
- Optional Life Insurance
- · Long Term Care
- The employee must be in a contract position and receive an EIA (Education Improvement Act of 1984) salary supplement. In addition to classroom teachers, this may also include other academic personnel such as librarian/media specialists, guidance counselors, ROTC (Reserve Officer Training Corps) instructors, school nurses, social workers, psychologists, audiologists, or other instructional staff. Contact the Department of Education at 803-734-8122 for additional information pertaining to the specific legislation or determining eligibility of a position.
- The employee must work at least fifteen hours per week, but fewer than 30 hours per week.
 - There are three part-time categories based on the number of hours worked per week (Category I = 15-19 hours; Category II = 20-24 hours; Category III = 25-29 hours). Premiums are based on the category.
- An employee eligible as a permanent, part-time teacher and also eligible as a dependent under a covered spouse's file may elect coverage as a permanent, part-time teacher or as dependent, but not both. A permanent, part-time teacher with health and/or dental coverage as a subscriber cannot be a dependent on the spouse's plan under any benefit (health, dental, long term care or dependent life).

Assisting a Permanent, Part-Time Teacher With Enrollment

- Eligible employees must enroll within 31 days of date of hire by completing a Permanent Part-time Teacher NOE.
- Effective dates of coverage are the same as for other new hires.
- The 31-day window for elections and changing elections is also the same as for other new hires.

Completing the NOE

The same procedures apply for completing the different sections of a permanent Part-Time Teacher NOE as for an Active NOE, with the following exceptions:

Section "C" Coverage

- 19. **CATEGORY**: Must select one category based on the number of hours worked each week. The BA should confirm the accuracy of the selection.
- 22. **BASIC LIFE/BASIC LTD**: NOT provided with health coverage and not available as a benefit to permanent, part-time teachers.

NOE Final Checklist - Permanent, Part-time Teacher

Check the NOE for the following:
☐ The NOE is an original - photocopies are unacceptable.
☐ The NOE is completed using BLACK INK.
\square No alterations appear (for example: strikeovers, correction fluid, multiple checks) in the coverage areas (blocks #19, 20, 21).
☐ The NOE is dated and signed by the employee (block #24).
☐ The employee made a coverage selection or checked "refuse" for health and dental and marked "YES" or "NO" for Dental Plus. If an HMO/POS is selected, the employee must list the HMO/POS name.
☐ Any required documents are stapled to the NOE:
☐ Dependents With Same or Different Last Name Form
☐ Student Certification Form
☐ Incapacitated Child Certification Form
☐ Custody/guardianship appointment (legal document or supporting document and Establishment of Custody Form)
☐ Divorce decree (court order to cover ex-spouse or children)
☐ Temporary adoption/custody/final adoption (legal document)
☐ Certificate(s) of prior coverage (from prior group carrier)
☐ Documentation of common law marriage
☐ Each attachment has the employee's name, SSN and the plan designation
☐ The SSN and date of birth for dependents are complete and, if applicable, state employee spouse is indicated
☐ Complete the BA USE ONLY area, sign and date the NOE and any appropriate documentation. Staple any attachments to the NOE.
☐ If the employee elected coverage through an HMO/POS, send a copy to the HMO/POS.

Keep a copy of the NOE and any documentation for your file and forward appropriate payroll deduction form(s).

Retiree Returns to Work

Refer to the Retirees section of the manual for information and procedures when a retired employee returns to work.

Rules and Procedures for Late Entrants (by program)

Health Insurance

- The employee must wait until the next open enrollment period to enroll as a late entrant or to add a dependent as a late entrant.
- There is no medical underwriting for subscribers or dependents.
- Late entrants into the health plan who enroll during an open enrollment period do not have to provide medical evidence of good health to be approved
- All late entrants are subject to a pre-existing condition limitation:
 - 18 months if not enrolled within 31 days of a special eligibility situation
 - 12 months if enrolled within 31 days of a special eligibility situation
 - Certification of continuous prior coverage may be provided to offset the pre-existing condition limitation period.

Dental Insurance

- The employee must wait until the next open enrollment period to enroll as a late entrant or to add a dependent as a late entrant.
- There is no dental underwriting for subscribers or dependents.
- There are no pre-existing condition limitations under the State Dental Plan or Dental Plus.

Life Insurance

Optional Life (Policy # GL33913)

- If they do not participate in the MoneyPlu\$ pretax premium feature, eligible participants may enroll in Optional Life or increase coverage throughout the year.
 - Medical evidence is required as a late entrant.
- If they do participate in the MoneyPlu\$ pretax premium feature, eligible participants may enroll in Optional Life or increase coverage during announced enrollment periods or within 31 days of a special eligibility situation.
 - Medical evidence of good health is required for late entrants.

Refer to "Other Coverage Changes" on Page B-31 for the procedures for adding and changing Optional Life Insurance coverage outside of a new hire situation.

Dependent Life/Child(ren) (Policy # GL33913)

- Eligible dependent children may be added throughout the year.
- No medical evidence of good health is required for children enrolled as late entrants.

Dependent Life/Spouse (Policy #GL33913)

- Eligible spouses may be added throughout the year.
- Medical evidence of good health is required for spouses enrolled as late entrants.

Refer to "Other Coverage Changes" in this section for the procedures for adding and increasing Dependent Life Insurance coverage with medical evidence of good health.

Supplemental Long Term Disability

(Policy #621144A)

- Complete the plan administrator section of the SLTD Medical History Statement.
- Have the employee complete the remainder.
- Send the completed original to Standard Insurance Company.
- When an approval is received from Standard, have the employee complete an SLTD Enrollment form to select the coverage for which he was approved. This may be done earlier and held for the approval from Standard.
- Send the SLTD Enrollment form to EIP. The approval must be stapled to the SLTD Enrollment form.
- Premiums start with the effective date of coverage (first of the month after approval).

Long-Term Care

(Policyholder/Control #654031)

Refer to "Other Coverage Changes" in this section for the procedures for adding and increasing Long Term Care Insurance coverage with medical evidence of good health.

Changes in Status

Special Eligibility Situations

(Health, Dental, Dependent Life)

Enrollment changes must be requested within 31 days of the special eligibility situations below, and any supporting documentation must be attached to the NOE. Changes not made within 31 days of the special eligibility situation cannot be made until the next open enrollment period.

Refer to the Spouses and Dependents section for eligibility rules and documentation for spouses and dependent children.

Marriage

- The eligible employee may enroll himself only or any eligible dependents in health and/or dental insurance. The subscriber must be on the plan or added with the dependent(s).
- Effective date: date of marriage

Birth of a Child

- The eligible employee may enroll himself only or any eligible dependents in health and/or dental insurance.
- The subscriber must be on the plan or added with the dependent(s).

Effective date: date of birth of the newborn

If the 31-day window to add the newborn is missed, EIP will need an NOE to add the infant for claims payment for the first 31 days, and an NOE is needed to drop him after the 31 days.

Adoption or Placement of a Child

- The eligible employee may enroll himself only or any eligible dependents in health and/or dental insurance. The subscriber must be on the plan or added with the dependent(s).
- *Effective date:*
 - Date of birth, if the baby is placed within 31 days of the date of birth and the adoption is completed within one year.
 - If not placed within 31 days of the date of birth, the effective date is the actual date of placement. The
 effective date to add a child adopted from overseas may also be the date the child arrived in the United
 States.
- Documentation must be attached to the NOE.

Special Note on Newborns

All individual and group health insurance policies that allow coverage for family members must provide coverage for newborns from the moment of birth. EIP requires a premium and notification of birth within 31 days after the date of birth. For coverage to continue beyond the 31-day period, notification must be received within 31 days after the date of birth. If notification is not provided within this time, the newborn child cannot be added to coverage until the next open enrollment period, and the late entrant, 18-month pre-existing condition limitation will apply. Pre-existing condition limits do not apply to newborns or adopted children added to the Plan as covered dependents as long as they are added to coverage when first eligible. Also, a premium will be required for the first 31-day period.

Involuntary Loss of Other Group Coverage

- The subscriber must already be on the plan or must be listed as having lost coverage.
- The involuntary loss must be because the employer canceled the insurance, a reduction in hours or because employment was terminated. The spouse's enrollment period or a voluntary cancellation of the policy does not constitute involuntary loss.
- Effective date: date of the loss of coverage
- A loss of coverage letter is required as documentation and must be attached to the NOE. The loss of coverage
 letter should be on company letterhead, and must state the employer's name, the effective date of the loss of
 coverage, the type of coverage lost (health and/or dental), list who was covered and give the reason for the
 coverage termination.
 - Only those eligible dependents who lost health and/or dental coverage may be added. The dependents may be added only to the coverage lost as stated on the loss of coverage letter. The letter must state lost health coverage to be added to health and must state lost dental coverage to be added to dental.
- The loss of coverage letter may be used as creditable coverage, provided all necessary information is included (beginning and ending effective dates and type of coverage). Otherwise, a creditable coverage letter needs to be submitted to offset any pre-existing conditions. The health carrier will notify the subscriber of any pre-existing limitations if the full 12 months of creditable coverage has not been established.

Court Order to Cover Child or Ex-Spouse

- Effective date: first of the month after the judge's signature date
- A copy of the court order must be attached to the NOE.
- The dependent(s) will be subject to a pre-existing condition limitation; however, creditable coverage documentation may be submitted to offset any pre-existing condition limitation.
- Dependents must be listed on the NOE and will be added only to the coverage stated in the court order.
- A court order does not usually address dependent life. Dependents may be added to dependent life only if specified in the court order.

Full-Time Student

- Effective date: first of the month after obtaining full-time student status
- A Student Certification Form and letter from the academic institution as required by the form must be attached
 to the NOE. The procedures for student certification are outlined in the "Spouses and Dependents" section of
 the manual.
- The dependent will be subject to a pre-existing condition limitation; however, creditable coverage documentation may be submitted to offset any pre-existing condition limitation.
- An eligible dependent student may be added to Dependent Life at any time throughout the year without medical evidence of good health.

Gaining Custody

- Effective date: date of custody
- Documentation is required and must be attached to the NOE.
- The dependent will be subject to a pre-existing condition limitation; however, creditable coverage documentation may be submitted to offset any pre-existing condition limitation.
- Eligible dependent children may be added to Dependent Life at any time throughout the year without medical evidence of good health.

Gain of Other Group Coverage

(Includes Medicare and Medicaid)

• An employee may terminate health and/or dental coverage if he gains other group coverage.

- An employee may drop dependents from coverage if he or his dependents gain other group coverage.
- Exception to the 31-day rule: A dependent who gains coverage or becomes eligible for coverage as a subscriber of a participating employer must be dropped; the employee cannot continue to cover him until the next open enrollment period. If the employee fails to drop the ineligible dependent within 31 days, the dependent may be dropped retroactively, up to 12 months.
- Effective date: first of the month after gaining other coverage

A gain of other group coverage letter is required documentation and must be attached to the NOE.

- The gain of coverage letter should be on company letterhead.
- The letter must include the company's name, the effective date of coverage, the type of coverage (health and/or dental), and list those who gained coverage.
- The gain coverage letter must state gained health coverage to decrease or terminate health coverage. The
 letter must state gained dental coverage to decrease or terminate dental coverage. *Exception*: Medicaid
 includes both health and dental coverage automatically.
- Only those dependents who gained other coverage may be dropped. The subscriber must have gained coverage also to terminate coverage.

Gain of Medicare Coverage

- Effective date: effective date of the Medicare coverage (or the first of the month after if requested)
- A copy of the Medicare card or letter verifying gain of Medicare coverage should be attached to the NOE.

Gain of Medicaid Coverage

- Effective date: effective date of the Medicaid coverage (or the first of the month after if requested)
- Exception to the 31-day rule: if the Medicaid effective date is made retroactive by the Department of Social Services (DSS) or if there was a delay in notification of eligibility by DSS, then:
 - The request to drop the dependents that gain Medicaid coverage must be made within 31 days of notification of approval for Medicaid. The effective date will be the first of the month after the request (if notification is more than 31 days from the effective date).
 - Verification of late notification or retroactive effective dates may be required (date stamp on the envelope or dated letter from DSS).
- A copy of the Medicaid approval must be attached to the NOE.

Dependent Child Turns Age 19 and is NOT a Full-Time Student

- Effective date to drop dependent: first of the month after the child's 19th birthday.
- Exception to 31-day rule: If the subscriber fails to request to drop the ineligible dependent within 31 days and this is the last eligible dependent child, the request to change the level of health, dental, and dependent life (if applicable) may be changed retroactively, up to 12 months.
 - However, the subscriber should request the change in coverage as soon as possible to avoid paying premiums for a higher level of coverage than is necessary.
 - The dependent child will be dropped from the system automatically, and any ineligible claims will not be paid.
- If the child is incapacitated, the incapacitation must be established with documentation prior to the child's 19th birthday.

Covered Dependent Child Loses Full-Time Student Status

(includes graduation)

- Effective date to drop dependent: first of the month after losing full-time student status
- Exception to 31-day rule: If the subscriber fails to make the request to drop the ineligible dependent within 31 days, the effective date will be effective the first of the month after the request. It is the subscriber's responsi-

bility to notify his benefits office when the child is no longer a full-time student. The subscriber may be liable for any claims paid on the behalf of an ineligible dependent.

Dependent Child Turns Age 25

- Effective date to drop dependent: first of the month after the child's 25th birthday
- Exception to 31-day rule: If the subscriber fails to make the request to drop the ineligible dependent within 31 days and this is the last eligible dependent child, the request to change the level of health, dental, and dependent life (if applicable) may be changed retroactively, up to 12 months.
 - However, the subscriber should request the change in coverage as soon as possible to avoid paying premiums for a higher level of coverage than is necessary.
 - The dependent child will be dropped from the system automatically, and any ineligible claims will not be paid.

Dependent Child Marries

- Effective date to drop dependent: first of the month after the date of marriage
- Exception to 31-day rule: If the subscriber fails to drop the ineligible dependent within 31 days, the effective date will be the first of the month after the request is made (per subscriber's signature date on the NOE).

Dependent Gains Employment With Coverage

Same as Dependent Child Marries (above).

Spouse Becomes an Eligible for Benefits as an Employee of a Participating Employer

• Effective date to drop spouse: the date coverage under EIP goes into effect

Spouse Gains Coverage as a Retiree Subscriber

If a spouse gains state benefits as a retiree, he is not eligible as a dependent and must be dropped from coverage.

- Effective date to drop spouse: the date the retiree benefits go into effect
- Exception: A spouse covered as a retiree subscriber may be considered a dependent under the state active file for Dependent Life coverage, provided the retiree is NOT in claim status (waiver of premium status) as a disability retiree on Optional Life. He may be added when the Optional Life waiver ends if requested within 31 days.

Divorce of Spouse

(Not required to be covered under court order)

- Effective date to drop spouse: the first of the month after the divorce becomes final
- Exception to 31-day rule: If the subscriber fails to drop the ex-spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made (subscriber's signature date on the NOE).

Separation From Spouse

- Effective date to drop spouse: the first of the month after the date of separation
- *Exception to 31-day rule:* If the subscriber fails to drop the separated spouse within 31 days, the effective date will be the first of the month after the request is made (subscriber's signature date on the NOE).
- Documentation is required to drop the spouse. Refer to the Spouses and Dependents section of the manual for examples of documentation.

When Divorce Is Final

• The separated spouse may remain on health, dental, and/or dependent life/spouse until the divorce is final. When the divorce is final, the subscriber must drop the ex-spouse from all programs, unless a court order requires him to continue to cover the ex-spouse. The court order must stipulate the programs under which the ex-spouse should be covered.

Reconciliation

- If a couple reconciles:
 - The deleted spouse and/or children must wait until the next open enrollment period to be reinstated for health insurance coverage, subject to an 18-month pre-existing period, or wait until a special eligibility situation occurs.
 - The spouse may re-enroll in Dependent Life/Spouse year-round by providing medical evidence of good health and being approved. Dental coverage may be reinstated only during the next open enrollment period or within 31 days of a special eligibility situation.

Death of Dependent (Spouse or Child)

- Effective date to drop dependent: Day after date of death
- Exception to 31-day rule: If the subscriber fails to make the request to drop the dependent within 31 days and this is the last eligible dependent, the request to change the level of health, dental, and dependent life (if applicable) may be changed retroactively, up to 12 months. However, the subscriber should request the change in coverage as soon as possible to avoid paying premiums for a higher level of coverage than is necessary.

MoneyPlu\$ Family Change in Status Rules

The rules and effective dates for changes in status are generally the same as for health insurance. Eligible employees have 31 days to enroll or to make changes following a qualifying change in status. Refer to the MoneyPlu\$ Change in Status form for eligible changes and their effective dates.

- Changes/new elections must be consistent with a qualifying family status change.
- Terminations of employment include transferring from one participating entity to another.
- **Dependent Care Account**—If a Dependent Care Account is terminated, the employee can continue to submit claims, while employed, until the end of the year or until the account is exhausted.
- **Medical Spending Account**—If a Medical Spending Account is terminated, the employee can only submit expenses incurred through the date of termination, unless continuing participation on an after-tax basis through COBRA.

Completing the Change In Status Form

- The type of change requested must be consistent with the special eligibility situating event.
- Enter the date of the event, not the effective date of the change.
- Complete the Payroll Calculation Summary for the pay periods remaining in the year.
- The employee must sign and date the form.
- The BA must complete the last section to confirm the eligibility of the change in status.
- Some payroll centers cannot handle before- and after-tax deduction changes during the year. All changes must then be made during the annual enrollment period.

Coverage Changes for Permanent, Part-Time Teachers

(Health and Dental)

The policies and procedures regarding health and dental changes for active subscribers also apply to permanent, part-time teachers.

Increase Or Decrease in the Number of Contract Hours

If the increase or decrease in an employee's contracted work hours causes a change in status (i.e., from 15 to 25 hours per week, etc.):

- Submit a new NOE, reflecting the change in status.
- If this is a temporary change, you do not have to notify EIP, and no changes should be made.
- If an increase in hours makes the employee eligible as a permanent, part-time teacher:
 - The date of hire will be the date of the contract change.
 - The Effective Date will be the first of the month after the date of the contract change (or the first working day of the month, if applicable).

If an employee's work hours are contractually reduced to fewer than 15 hours per week:

• Complete and send an Active Termination Form to EIP, effective the first of the month after the work hours are reduced.

The employee may make new health and dental selections based on an increase or decrease in hours.

- If the decrease in hours places the employee in a lower category (i.e., he enrolled in Category III working 26 hours and the contract changes to 23 hours), he may decrease or cancel his coverage.
- If the increase in hours places the employee in a higher category (i.e., he enrolled in Category I working 17 hours and the contract changes to 23 hours), he may select and/or increase his benefits.
- If the increase in hours reaches 30 hours per week, classifying him as a permanent, full-time employee, he is eligible to make all new selections. Treat him as a new hire and offer all benefits to him, effective the first of the month after he reaches permanent, full-time status.

Other Coverage Changes (by program)

Optional Life

Use an NOE to make a change to Optional Life coverage.

• The BA must mark the NOE indicating "YES" or "NO" in the MoneyPlu\$ section at the top right of the NOE when Optional Life changes are requested to indicate whether the employee participates in the MoneyPlu\$ Pretax Premium Feature.

Subscribers NOT participating in the MoneyPlu\$ Pretax Premium Feature may (the 31-day rule does not apply if NOT participating in the Pretax Premium Feature):

- Add or increase coverage:
 - Complete a Personal Health Statement form and submit it to the Hartford for review.
 - The effective date will be the first of the month after approval from The Hartford.
- **Decrease coverage** (effective the first of the month after the request).
- Cancel coverage (effective the first of the month after the request).

Subscribers participating in the MoneyPlu\$ Pretax Premium Feature may (changes must be made within 31 days of the qualifying event or the employee must wait until the next enrollment period):

- Add coverage. The Optional Life request must be consistent with the special eligibility situation (such as to add Optional Life coverage due to marriage).
 - Medical evidence of good health is not required.
 - The effective date of the change will be the date of the special eligibility situation.
 - If the subscriber refused Optional Life as a new hire, he may:
 - ^o Add coverage, up to three times annual salary (rounded down to the nearest \$10,000), without medical evidence of good health.
 - ~ The effective date will be the date of the event.
 - ° Add coverage, more than three times annual salary (rounded down to the nearest \$10,000), with medical evidence of good health.
 - ~ Complete a Personal Health Statement form and submit it to The Hartford for review.
 - ~ Complete two NOEs. Complete the first NOE, requesting the level for which he is eligible without medical evidence, effective the date of the event. Complete the second NOE for the remaining coverage, up to the maximum, and hold until the approval is received from The Hartford.
 - ~ Once approved, the second NOE should be sent to EIP for processing with the approval attached.
 - ~ The effective date will be the first of the month after approval from The Hartford.
- Increase coverage, up to an additional \$50,000, without medical evidence of good health.
 - The effective date will be the date of the event.
- Increase coverage, more than \$50,000, with medical evidence of good health.
 - Complete a Personal Health Statement form and submit it to The Hartford for review.
 - Complete two NOEs:
 - ^o Complete the first NOE, requesting the level for which he is eligible without medical evidence (\$50,000), effective the date of special eligibility situation.
 - ° Complete the second NOE for the remaining coverage, up to the maximum, and hold until the approval is received from The Hartford.
 - ° Once approved, the second NOE should be sent to EIP for processing with the approval attached.

- **Decrease coverage.** The Optional Life request must be consistent with the special eligibility situation (such as to decrease Optional Life coverage due to death of a dependent).
 - The effective date will be the date of the event. Exception: The effective date for the death of a spouse will be the day after death as with other benefits.
- Cancel coverage. The Optional Life request must be consistent with the special eligibility situation (such as to cancel Optional Life coverage due to death of a dependent).
 - The effective date will be the date of the event. Exception: The effective date for the death of a spouse will be the day after death as with other benefits.

Effective Date NOTE: If the employee is not at work on the date his Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the day after the employee returns to work for one full day.

If Hartford denies additional coverage, based on medical evidence:

- The employee may request from The Hartford, in writing, additional information regarding the denial.
- Do not forward denials to EIP.
- If denied, the employee may reapply by submitting a new Personal Health Statement.

Dependent Life

Dependent Life/Child

- Changes must be made on an NOE, dated and signed by the subscriber and the BA.
- Coverage may be canceled upon request, effective the first of the month after the request is made (or up to 12 months retroactively if dropping the last eligible dependent child due to death or if the system terminates the last eligible dependent child).
- Coverage may be added throughout the year, effective the first of the month after the request.

Dependent Life/Spouse

- Coverage up to \$20,000 may be added within 31 days of date of marriage without providing medical evidence of good health.
- Coverage may be added, increased, decreased or cancelled throughout the year.
- Medical evidence of good health (medical underwriting) is required for late entry and to increase Dependent Life/Spouse coverage beyond \$20,000.
- Medical evidence of good health procedures:
 - Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
 - Complete a Personal Health Statement form and submit it to The Hartford for review.
 - Once approved, the NOE should be sent to EIP for processing with the approval attached.
 - The effective date will be the first of the month after approval from The Hartford.

If The Hartford denies coverage, refer to the Optional Life Insurance denial information above.

Supplemental Long Term Disability

Changes allowed throughout the year:

- **Cancel coverage**-effective the first of the month following the request.
- **Increase the waiting period**-effective the first of the month following the request.
- **Reduce the waiting period**-medical evidence of good health is required.
 - Effective the first of the month following approval.

- Add coverage if late entrant-medical evidence of good health is required.
 - Effective the first of the month following approval.

All changes must be made using the Supplemental Long Term Disability Enrollment Form. The form must be signed and dated by both the subscriber and the BA. A Medical History Statement must also be completed for medical evidence of good health.

Long Term Care

These changes are allowed at any time throughout the year, outside of an announced enrollment period:

- Add or increase coverage with medical evidence of good health.
 - To add or increase coverage, the enrollee must complete a Group Long Term Care Insurance Medical Questionnaire Enrollment Form and send it to Aetna.
 - The effective date will be the first of the month following approval from Aetna. Parties are notified as follows:
 - ° Aetna notifies employees and retirees of approval/denial.
 - ° Aetna forwards approvals for active employees and retirees to EIP. EIP processes applications for payroll deductions for active employees, retirees and spouses.
 - ° EIP notifies BAs of approvals for active subscribers and their spouses by forwarding a copy of Aetna's approval.
 - ° EIP notifies retirees of approvals for themselves and their spouses.
 - ° Aetna will notify parents and parents-in-law of approvals or denials. Parents and parents-in-law pay their premiums directly to Aetna.
 - Or The new premium amount will be based on the age at the time the questionnaire is received by Aetna. Be sure to notify EIP if both spouses are enrolled in the service reimbursement plans so they may get the discount.
- Decrease or cancel coverage-effective the first of the month following the request.
 - Requests to decrease or cancel coverage may be made in writing, with a statement signed and dated by the subscriber, or by using the Long Term Care Change Request form. This form is available on the EIP Web site. The BA should forward the original to EIP for processing and keep a copy for the subscriber's file.

Beneficiary Changes (by program)

Basic Life/Optional Life

- Complete an NOE to change a beneficiary designee for Basic Life and/or Optional Life.
- An attachment is acceptable when the number of designated beneficiaries exceeds the allotted space on the NOE.
 - Indicate on the NOE that beneficiaries are continued, or may be listed entirely, on an attachment.
 - On the attachment, indicate the employee's name, SSN and the life insurance program with the same beneficiary information that is requested on the NOE. The attachment must be signed and dated by the subscriber and stapled to the NOE.
- When multiple beneficiaries are listed, indicate percentages (not money amounts); otherwise, the money will be divided equally among beneficiaries.
- The effective date will be the subscriber's signature date on the NOE.
- Send EIP the original and keep a copy for your files.

Long Term Care

- Complete a Long Term Care Change Request form. This form is available on the EIP Web site. On the form, include: The effective date of change;
- The new beneficiary(ies);
- The percentage of distribution to each beneficiary.
- Attach a separate sheet, if necessary.
- The BA should forward the original to EIP for processing and keep a copy for the subscriber's file.

Annual and Open Enrollment for Active Subscribers

Annual Enrollment

Annual enrollment is held every year during October. Changes become effective the following January 1.

- Employees may change from one health plan to another. Health plan changes are allowed each annual enrollment period for active subscribers.
- Employees may enroll in MoneyPlu\$ features.
 - Employees must re-enroll in the MoneyPlu\$ Medical Spending Account and/or Dependent Care account each year.
 - The subscriber remains on the MoneyPlu\$ pre-tax premium feature and does not need to re-enroll.
- Programs other than health may be added or changed as announced by EIP.
- Subscribers participating in the MoneyPlu\$ Pretax Premium feature may elect, make changes, or cancel Optional Life. Medical evidence of good health may be required.

Open Enrollment

Open enrollment period is held during October in odd-numbered years (2005, 2007, etc.). Allowed changes become effective the following January 1.

- Employees may enroll themselves and any eligible dependents without providing medical evidence of good health:
 - Subject to an 18-month pre-existing condition period, unless enrolled within 31 days of a special eligibility situation.
 - A certificate of creditable coverage may be submitted to reduce the pre-existing condition limitation period.
- Employees may cancel health coverage or drop dependents from health coverage.
- Employees may change from one health plan to another.
- Employees may enroll in, cancel, or add or drop dependents from the State Dental plan or Dental Plus.
- Employees may enroll in MoneyPlu\$ features.
 - Employees must re-enroll in the MoneyPlu\$ Medical Spending Account and/or Dependent Care account each year.
 - The subscriber remains on the MoneyPlu\$ pre-tax premium feature and does not need to re-enroll.
- Subscribers participating in the MoneyPlu\$ Pretax Premium feature may elect, make changes, or cancel Optional Life. Medical evidence of good health may be required.
- Changes to other programs may be made as announced.

New Employees or Transfers Hired November 1-December 31

New Employees

• If the health plan the new employee selected for the remainder of the year will not be available to the employee on January 1, or if he wishes to enroll in a plan that won't be available until then, he may change his health plan election for the coming year.

Transfers

Employees who transfer from one participating employer to another with no break in coverage should make their enrollment elections as usual: during October, while still employed with the previous employer.

- The subscriber should advise the new employer of his October elections at the time of the transfer.
- If the health plan selected is not available to the employee as a result of moving/relocation, he may change his health plan.

Annual/Open Enrollment Procedures and Helpful Hints

- You do not have to wait until October 1 to begin enrollment. You may begin early, if you wish.
- Only the requested changes need to be marked on the NOE. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections.
- The "change-mind-within-31-days" policy does NOT apply.
- Any changes requested must be submitted on an NOE and signed by October 31.
 - Mark "REVISED OE" or "REVISED AE" on the NOE
 - The revised NOE must include all changes the subscriber wishes to make for the new year, because this NOE will replace any NOEs submitted previously.
 - When in doubt, if more than one NOE is submitted, EIP will process the NOE with the latest signature date as the enrollment NOE.
- NOEs must be signed by October 31.
- Write "OE" or "AE" at the top of the NOE to indicate it is for open enrollment or annual enrollment.
- Do not hold enrollment NOEs. Send them to EIP as they are completed.
- All enrollment NOEs must be received by EIP by November 15—no exceptions!
- The SSN and name of the subscriber must be on the NOE.
- The effective date, group number and group name must also be on the NOE
- When making health and/or dental plan changes, any dependents to be added or deleted should be listed.
- Indicate "address change" if applicable. Include the new address on both the AE or OE NOE and a regular NOE, so EIP can update the address immediately.
- Staple any required documentation to the NOE.
- Staple letters of creditable coverage, if available, to the NOE when adding dependents.
- The NOE must be signed by the BA and by the employee.
 - Exception: If an HMO/POS is no longer available, causing a necessary change in the health plan election, and the employee fails to complete an NOE selecting a new health carrier, the BA must complete the NOE, indicating at the top "HMO/POS not in service area." The default will be the Standard Plan, with the same level of coverage that he had with the HMO/POS.

Special Rules Regarding Approved Leave

Additional information regarding reporting during approved leave periods is in the Accounting, Billing and Reports section of the manual.

If leave is directed and paid by the participating employer, insurance coverage should be continued, and the employer should pay the employer share of premium.

Workers' Compensation

An employee on approved leave because of disability approved by the Workers' Compensation Benefits Program is considered to be drawing a salary from the state.

- The employee sends the monthly payment of the employee contribution, by personal check, to the employer's payroll office.
- The employer pays the employer portion of the premium.

Educational Leave (Sabbatical Leave)

The head (or designated deciding official) of a participating employer is authorized to approve educational LWOP only when it will be to the advantage and benefit of the employer.

- The deciding official may approve leave for the length of the school term or terms requested, not to exceed 12 months.
- At the end of this period, upon request by the employee, the official may approve additional leave for a period of no more than 12 months.

Leave Without Pay (LWOP)

- When an employee is on approved leave without pay (LWOP) for an entire calendar month and does not work at least one full day or use one full day of annual or sick leave, he pays the total premium (employee and employer share for health, dental, life and LTD) to the employer's payroll office.
- An employee on LWOP cannot remain on active status indefinitely. EIP uses statewide leave policies administered by the South Carolina State Budget and Control Board Office of Human Resources to regulate the employment status of an employee.

LWOP Due to Disability

- If an employee is on LWOP due to disability, his Optional Life premium should be waived for 12 months:
 - Complete the State Optional Life (and SLTD) Premium Waiver Form and forward it to EIP.
 - LTC and SLTD premium waivers begin with approval of an employee's claim.
- If an employee is on LWOP due to total disability, the employee may be eligible to enroll in the retiree insurance program and/or receive an extension of Optional Life coverage, if enrolled.
- Academic employees who begin disability leave during the school year and continue into the summer months
 and are not on paid leave should pay the entire premium (employee and employer share) until they present the
 school district personnel office with a doctor's release to return to work.
- If the employee is on LWOP for any reason other than disability, explain to the employee that Basic Life and BLTD coverage can only be continued for 12 months.

Procedures When an Employee Is in LWOP Status

- If LWOP is at the employee's expense, but leave is sanctioned by the employer:
 - Insurance coverage should be continued, and the employee should pay the total premium (employee and employer share).

- If working hours have been reduced to fewer than 30 per week (20, if applicable, based on employer election) AND the leave is directed by the employer to further education AND the employer is paying the expenses:
 - Insurance coverage should be continued, and the employer should pay the employer share of premium.
- If working hours have been reduced to fewer than 30 per week (20, if applicable, based on employer election) AND the leave is sanctioned by the employer to further education, BUT the employee is paying the expenses:
 - Insurance coverage should be continued, and the employee should pay the total premium (employee and employer share).
- If working hours have been reduced to fewer than 30 per week (20, if applicable, based on employer election), BUT the employee is furthering education for his own advancement, AND the employee is paying the expenses:
 - Insurance coverage should be terminated and coverage under COBRA offered.

Military Leave Without Pay

When an employee is called to active duty, the employee may continue his health and dental coverage, and the employer would continue to pay the employer share of premiums.

• Coverage will be subject to exclusions for military as outlined in the IBG.

If employee terminates coverage during his leave period, coverage may be reinstated upon returning to work.

- The request to reinstate coverage must be made within 31 days of discharge or the loss of military insurance coverage.
- The employee is reinstated with a break in coverage and at the same level of coverage, unless a special eligibility situation has occurred.
- Any pre-existing condition limitation period is based on the original date of employment, not the date the employee returned to work.

Family and Medical Leave Act of 1993

(as it applies to insurance coverage)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave to employees for certain family and medical reasons.

Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits and other employment terms. The use of FMLA leave cannot result in the loss of any employment benefit that accrued before the start of an employee's leave.

If the Employee Requests to Continue Coverage During FMLA

- The employer must maintain group health coverage, on the same conditions as coverage would have been provided, had the employee been continually employed during the entire leave, including new benefits, benefit changes and enrollment periods.
- The employee must continue paying the employee share of premiums during the leave period.
 - The employer must provide the employee advance, written notice of the terms and conditions under which the employee premium payment must be made.
 - There should be a 30-day grace period on premium payments.
- If the employee fails to make a timely payment:
 - The employer may choose to pay the employee's share of premium payments for the remainder of the leave period and recover the amount from the employee when the employee returns to work.
 - Coverage may be canceled.

- If the employee fails to return to work:
 - The employer can recover from the employee the employer share of premiums paid during the period of leave, unless one or more of the following occurs:
 - ^o The employee does not return to work due to the continuation, recurrence, or onset of a serious health condition that would entitle the employee to leave. Medical certification may be required.
 - ° There are other circumstances beyond the employee's control, such as the spouse unexpectedly is transferred to a job location more than 75 miles away or the employee is laid off while on leave.
 - ° The employee is a "key employee" who decides not to return to work.

If the Employee Decides to Drop Coverage During FMLA

- Upon return to work, the employee must be reinstated on the same terms and conditions without any qualifying period, medical evidence of good health, exclusion or pre-existing limitations.
- Write on top of the new NOE, "Employee returning from FMLA—pre-existing does not apply."

Coverage Changes During/After Approved Leave

- An employee may drop or decrease coverage while on approved leave.
- When returning from approved leave, the employee must be reinstated within 31 days, with the same coverage in effect at the time approved leave was established, unless a qualifying event occurred while on leave.
 - Documentation may be required.
 - Reinstatement is effective the first of the month after returning to work.
 - This also applies to employees who canceled all coverage while on leave.
- If any eligible dependents were dropped initially or at any time while on LWOP, the employee must reinstate those eligible dependents, provided they are still eligible and provided they were covered at the time the LWOP status was established.
- If reinstatement of coverage is not requested within 31 days of returning to work, the employee and any eligible dependents must wait until the next open enrollment period to enroll as a late entrant.

MoneyPlu\$ Leave of Absence

There are three ways to manage an employee's spending account elections during an approved leave of absence:

- 1. **Prepay.** The employee is given the opportunity to prepay the deductions on a pre-tax basis.
- 2. **Pay-as-you-go**. The employee is given the opportunity to pay with post-tax and/or pre-tax (to the extent the employee receives compensation).
 - Collect the deductions from the employee and include the money with the deposit covering the active employee deductions for any given payroll period.
 - The employer must send something in writing to FBMC's Consolidated Billing Department with the employee's SSN, name, check/FSA collection amount and the payroll date(s) collected.
- 3. **Catch-up**. The employee and the employer agree that the employer pays the premium on the employee's behalf during leave, and the employee repays the employer upon return. Provisions for catch-up are between the employer and the employee. This must be decided prior to leave.

If the employee goes on unpaid leave and does not continue to contribute:

- Notify Consolidated Billing that the person is on unpaid leave and will not be continuing his FSA(s).
- Notify Consolidated Billing when the person returns from leave if his deductions will resume.

Administrative Errors (Requests for Approval)

- Requests for approval should be submitted to EIP, using a Request for Approval Form.
- Use the Request for Approval Form only when the benefits office has made a clerical or delay error, has misinformed the enrollee or has misplaced a completed NOE.
- Employee negligence does not constitute an administrative error.
 - The BA's signature is required, certifying the error was caused by the agency, school district or local subdivision and was, in no way, the fault of the employee (such as the employee failed to submit an NOE within 31 days).
 - Include complete details, and attach all relevant documentation. Attach an additional explanation sheet, if necessary.
 - Always include the group name, employee's name, SSN and date of request.
 - Attach to the Request for Approval Form an original NOE, if applicable, completed and signed by the
 employee and you, and any supporting documentation. The NOE must correct the error addressed on the
 form.
- A Request for Approval Form must be attached to an NOE whenever an effective date correction is more than three months retroactive.
- A Request for Approval is not required for retroactive terminations of a subscriber's file. Employers are responsible for any premium liability more than 90 days retroactive to the date of termination.